

		FOR OFF USE					

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**2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0042648</u> Facility Name: <u>Manorcare of Northbrook</u> Address: <u>3300 Milwaukee Avenue</u> <u>Northbrook</u> <u>60062</u> <div style="display: flex; justify-content: space-around; width: 100%;"> Number City Zip Code </div> County: <u>Cook</u> Telephone Number: <u>(847) 795-9700</u> Fax # <u>(847) 795-9600</u> IDPA ID Number: <u>520886946022</u> Date of Initial License for Current Owners: <u>03/22/99</u> Type of Ownership: <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </div> <div> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </div> <div> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </div> </div>	
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In the event there are further questions about this report, please contact:
Name Craig Dekany **Telephone Number:** (419) 252-5740

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number Manorcare of Northbrook# 0042648 Report Period Beginning: 06/01/99 Ending: 05/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>148</u>	Skilled (SNF)	<u>148</u>	<u>54,168</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>148</u>	TOTALS	<u>148</u>	<u>54,168</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment	3	4	5	
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>3,500</u>	<u>3,726</u>	<u>5,134</u>	<u>12,360</u>	8
9	SNF/PED					9
10	ICF	<u>1,635</u>	<u>11,191</u>	<u>147</u>	<u>12,973</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>5,135</u>	<u>14,917</u>	<u>5,281</u>	<u>25,333</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4 46.77%)D. How many bed-hold days during this year were paid by Public Aid?
11 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/AF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 03/22/99J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 62 and days of care provided 3610Medicare Intermediary BCBS Maryland

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☐ NO ☒Tax Year: 12/31/00 Fiscal Year: 05/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Manorcare of Northbrook # 0042648 Report Period Beginning: 06/01/99 Ending: 05/31/00
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	159,785	6,948	4,673	171,406	498	171,904	0	171,904		1
2	Food Purchase		116,973		116,973		116,973	(943)	116,030		2
3	Housekeeping	118,173	19,556	0	137,729		137,729	0	137,729		3
4	Laundry	13,981	6,984	1,711	22,676		22,676	(10,805)	11,871		4
5	Heat and Other Utilities			123,161	123,161	5,911	129,072	0	129,072		5
6	Maintenance	31,340	15,399	34,814	81,553		81,553	0	81,553		6
7	Other (specify): Medical Waste			1,458	1,458		1,458	0	1,458		7
8	TOTAL General Services	323,279	165,860	165,817	654,956	6,409	661,365	(11,748)	649,617		8
	B. Health Care and Programs										
9	Medical Director			16,250	16,250		16,250	0	16,250		9
10	Nursing and Medical Records	1,391,179	110,852	16,731	1,518,762	8,002	1,526,764	0	1,526,764		10
10a	Therapy	145,334	4,334	11,911	161,579		161,579	0	161,579		10a
11	Activities	57,461	2,231	3,082	62,774		62,774	0	62,774		11
12	Social Services	50,608	408	415	51,431		51,431	0	51,431		12
13	Nurse Aide Training							0			13
14	Program Transportation							0			14
15	Other (specify):*							0			15
16	TOTAL Health Care and Progra	1,644,582	117,825	48,389	1,810,796	8,002	1,818,798		1,818,798		16
	C. General Administration										
17	Administrative	156,938		128,322	285,260	(25,283)	259,977	0	259,977		17
18	Directors Fees							0			18
19	Professional Services			444	444		444	(444)			19
20	Dues, Fees, Subscriptions & Promotions			58,000	58,000		58,000	(32,617)	25,383		20
21	Clerical & General Office Expense	213,548	27,767	233,428	474,743	1,025	475,768	(189,200)	286,568		21
22	Employee Benefits & Payroll Taxes			345,020	345,020	666	345,686	0	345,686		22
23	Inservice Training & Education			1,596	1,596		1,596	0	1,596		23
24	Travel and Seminar			3,484	3,484	(1,025)	2,459	0	2,459		24
25	Other Admin. Staff Transportation							0			25
26	Insurance-Prop.Liab.Malpractice			41,115	41,115		41,115	0	41,115		26
27	Other (specify):*							0			27
28	TOTAL General Administration	370,486	27,767	811,409	1,209,662	(24,617)	1,185,045	(222,261)	962,784		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,338,347	311,452	1,025,615	3,675,414	(10,206)	3,665,208	(234,009)	3,431,199		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Manorcare of Northbrook # 0042648 Report Period Beginning: 06/01/99 Ending: 05/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			4,986	4,986	10,206	15,192	0	15,192		30
31	Amortization of Pre-Op. & Org.							0			31
32	Interest			78	78		78	(11,355)	(11,277)		32
33	Real Estate Taxes			47,196	47,196		47,196	0	47,196		33
34	Rent-Facility & Grounds							0			34
35	Rent-Equipment & Vehicles			19,291	19,291		19,291	0	19,291		35
36	Other (specify):*							0			36
37	TOTAL Ownership			71,551	71,551	10,206	81,757	(11,355)	70,402		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation							0			38
39	Ancillary Service Centers		122,811	22,452	145,263		145,263	0	145,263		39
40	Barber and Beauty Shops			11,051	11,051		11,051	0	11,051		40
41	Coffee and Gift Shops							0			41
42	Provider Participation Fee			81,252	81,252		81,252	0	81,252		42
43	Other (specify):*		40,182	0	40,182		40,182	0	40,182		43
44	TOTAL Special Cost Centers		162,993	114,755	277,748		277,748		277,748		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,338,347	474,445	1,211,921	4,024,713	0	4,024,713	(245,364)	3,779,349		45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

STATE OF ILLINOIS

Page 5

Facility Name & ID Number Manorcare of Northbrook

0042648

Report Period Beginning: 06/01/99

Ending: 05/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1 Amount	2 Refer- ence	3 OHF USE ONLY	
	NON-ALLOWABLE EXPENSES				
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program:				3
4	Non-Patient Meals	(943)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,951)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(10,805)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(11,355)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(5,954)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(748)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,250)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(444)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(175,297)	21		24
25	Fund Raising, Advertising and Promotional	(32,617)	20		25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax				27
28	Nurse Aide Training for Non-Employees				28
29	Yellow Page Advertising				29
30	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (245,364)		\$	30

OHF USE ONLY

48		49		50		51		52	
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B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (245,364)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference
38	Medically Necessary Transport		x	\$	38
39					39
40	Gift and Coffee Shops		x		40
41	Barber and Beauty Shops		x		41
42	Laboratory and Radiology		x		42
43	Prescription Drugs		x		43
44	Exceptional Care Program		x		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

Print Preview

Print Rows 29 and 30 of Page 5 starting in B44 (DO NOT DRAG AND DROP CELLS)

The amounts in column F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS

Page 5b

Facility Name: **Ministry of Agriculture**

Report Period Beginning: **01/01/19**

Ending: **12/31/19**

Sub. V Line

NON-ALLOWABLE EXPENSES

The information listed in B13 thru G43 is from Page 5.

	Amount	Reference
1. Dog Care	0	Line 1
2. Other Care for Dependents	0	Line 2
3. Governmental Sponsored Special Programs	0	Line 3
4. Non-Patient Health	(1,912)	Line 4
5. Telephone, TV & Radio in Resident Rooms	(1,951)	Line 5
6. Laundry Supply Items	0	Line 6
7. Sale of Supplies to Non-Patients	0	Line 7
8. Laundry for Non-Patients	(10,303)	Line 8
9. Non-Volunteer Repatriation	0	Line 9
10. Interest and Other Investment Income	(11,375)	Line 10
11. Dividends, Allocations, Refunds & Refunds	0	Line 11a
12. Non-Working Officer or Owner's Salary	0	Line 12
13. Sales Tax	(1,954)	Line 13
14. Non-Car Related Interest	0	Line 14
15. Non-Car Related Owner's Payments	0	Line 15
16. Personal Expenses (Including Transportation)	(740)	Line 16
17. Non-Car Related Fees	0	Line 17
18. Personal Expenses	0	Line 18
19. Contributions	0	Line 19
20. Contributions	(1,290)	Line 20
21. Interest on Real-Estate Mortgage	0	Line 21
22. Special Legal Fees & Legal Retainers	(444)	Line 22
23. Mortgage Insurance for Individuals	0	Line 23
24. Real Estate	(175,287)	Line 24
25. Travel Expenses, Advertising and Promotional	(22,475)	Line 25
26. Interest & R. Personal Property Replacement	0	Line 26
27. Non-Car Training for Non-Employees	0	Line 27
28. Office Page Advertising	0	Line 28
29. Non-Paid Workers	0	Line 29
30. Personal Goods	0	Line 30
31. Miscellaneous Expenses	0	Line 31

Adj. Summary

Line 1

Line 2

Line 3

Line 4

Line 5

Line 6

Line 7

Line 8

Line 9

Line 10

Line 11a

Line 12

Line 13

Line 14

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SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.

IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb Manorcare of Northbrook

0042648 Report Period Beginning:

06/01/99

Ending: 05/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
A. General Services												
1 Dietary	0	0	0	0	0	0	0	0	0	0	0	0 1
2 Food Purchase	(943)	0	0	0	0	0	0	0	0	0	0	(943) 2
3 Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0 3
4 Laundry	(10,805)	0	0	0	0	0	0	0	0	0	0	(10,805) 4
5 Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0 5
6 Maintenance	0	0	0	0	0	0	0	0	0	0	0	0 6
7 Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 7
8 TOTAL General Services	(11,748)	0	0	0	0	0	0	0	0	0	0	(11,748) 8
B. Health Care and Programs												
9 Medical Director	0	0	0	0	0	0	0	0	0	0	0	0 9
10 Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0 10
10a Therapy	0	0	0	0	0	0	0	0	0	0	0	0 10a
11 Activities	0	0	0	0	0	0	0	0	0	0	0	0 11
12 Social Services	0	0	0	0	0	0	0	0	0	0	0	0 12
13 Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0 13
14 Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0 14
15 Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 15
16 TOTAL Health Care and Program	0	0	0	0	0	0	0	0	0	0	0	0 16
C. General Administration												
17 Administrative	0	0	0	0	0	0	0	0	0	0	0	0 17
18 Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0 18
19 Professional Services	(444)	0	0	0	0	0	0	0	0	0	0	(444) 19
20 Fees, Subscriptions & Promotions	(32,617)	0	0	0	0	0	0	0	0	0	0	(32,617) 20
21 Clerical & General Office Expenses	(189,200)	0	0	0	0	0	0	0	0	0	0	(189,200) 21
22 Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0 22
23 Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0 23
24 Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0 24
25 Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0 25
26 Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0 26
27 Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 27
28 TOTAL General Administration	(222,261)	0	0	0	0	0	0	0	0	0	0	(222,261) 28
TOTAL Operating Expense												
29 (sum of lines 8,16 & 28)	(234,009)	0	0	0	0	0	0	0	0	0	0	(234,009) 29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary B

Facility Name & ID Number: Manorcare of Northbrook

0042648

Report Period Beginning:

06/01/99

Ending:

05/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,355)	0	0	0	0	0	0	0	0	0	0	(11,355)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(11,355)	0	0	0	0	0	0	0	0	0	0	(11,355)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(245,364)	0	0	0	0	0	0	0	0	0	0	(245,364)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number:

Measurecare of Northbrook, Inc.

Show Pgs 6A thru 6
 Show Pgs 6B thru 6
 Hide Pgs 6A thru 6

STATE OF ILLINOIS

Report Period Beginning: 06/01/09
 Ending: 05/31/10

VII. RELATED PARTIES

Show Pgs 6A thru 6
 Show Pgs 6B thru 6
 Hide Pgs 6A thru 6

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

OWNERS			RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business	
MeasureCare, Inc.	100	Health Care & Retirement Corporation	Indian, OH				
		SEE ALSO: CAREY BENEFIT					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ Yes
 ☐ No

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for disclosing costs as specified for this form.

Schedule	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Costs of Related Organization	Reallocations to Related Organization (Line C, column 6)
1	V	Supplies	126,374	HCM Health Care, Inc.	100.00%	126,374	
2	V	Payroll					
3	V						
4	V						
5	V	Health Management	6,873	Health Management Services	100.00%	6,873	
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	V						
15	V						
16	V						
17	V						
18	V						
19	V						
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207	V						
208	V						
209	V						
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213	V						
214	V						
215	V						
216	V						
217	V						
218	V						
219	V						
220	V						
221	V						
222	V						

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees)
**FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
 ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Print Preview

| the name(s)
PORTS.

Facility Name & ID Number Manorcare of Northbrook# 0042648 Report Period Beginning: 06/01/99Ending: 05/31/00

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8

Show Pgs 8E thru 8

Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization HCR ManorCare, Inc.Street Address 333 North SummitCity / State / Zip Code Toledo, OH 43604Phone Number (419) 252-5500Fax Number (419) 254-5495

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1 Dietary	Accumulated Cost	#####	357 Nurs. Fac.	\$ 388,478	\$ 221,496	128,322	\$ 498	1
2	5 Utilities	Accumulated Cost	#####	357 Nurs. Fac.	4,614,666		128,322	5,911	2
3	10 Nursing	Accumulated Cost	#####	357 Nurs. Fac.	6,247,503	4,177,723	128,322	8,002	3
4	17 General & Administrative	Accumulated Cost	#####	357 Nurs. Fac.	80,443,795	26,746,978	128,322	103,039	4
5	22 Employee Benefits	Accumulated Cost	#####	357 Nurs. Fac.	520,233		128,322	666	5
6	30 Depreciation	Accumulated Cost	#####	357 Nurs. Fac.	7,968,019		128,322	10,206	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 100,182,694	\$ 31,146,197		\$ 128,322	25

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	N/A						\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$					\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$					\$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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Facility Name & ID Number Manorcare of Northbrook# 0042648Report Period Beginning: 06/01/99Ending: 05/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	<u>47,196</u>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	<u>47,196</u>	2
3. Under or (over) accrual (line 2 minus line 1).	\$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<u>47,196</u>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	<u>47,196</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995		8
	1996		9
	1997		10
	1998	<u>0</u>	11
	1999	<u>42,000</u>	12

R/E Tax Payments

<u>1999 \$21,790.13</u>			
<u>2000 \$25,405.93</u>			

FOR OFF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATIO	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,859 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 2

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1999	\$ 1,850,000	1
2					2
3	TOTALS			\$ 1,850,000	3

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12

Show Pgs 12C and 12

Hide Pgs 12A thru 12

STATE OF ILLINOIS

Page 12

Facility Name & ID Number Manorcare of Northbrook

0042648

Report Period Beginning:

06/01/99

Ending:

05/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	148			1999	\$ 9,216,829	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9	Leasehold Improvements (Current Year Depreciation)					372		372		417	9
10				1999	531						10
11				1999	1,470						11
12				1999	73						12
13				1999	449						13
14											14
15											15
16											16
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$ 372		\$ 372	\$	\$ 417	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number Manorcare of Northbrook# 0042648Report Period Beginning: 06/01/99 Ending: 05/31/00**XI. OWNERSHIP COSTS (continued)****C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 1,080,213	\$ 4,614	\$ 4,614	\$		\$ 4,587	37
38	Current Year Purchases	24,664						38
39	Fully Depreciated Assets							39
40	H/O Allocation			10,206	10,206			40
41	TOTALS	\$ 1,104,877	\$ 4,614	\$ 14,820	\$ 10,206		\$ 4,587	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 4,986	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 15,192	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 10,206	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 5,004	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58	CIP	\$ 1,086,842	58
59			59
60			60
61		\$ 1,086,842	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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XII. RENTAL COSTS**A. Building and Fixed Equipment (See instructions.)**1. Name of Party Holding Lease N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.9. Option to Buy: ☐ YES ☐ NO Terms: _____ ***B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☒ YES☐ NO16. Rental Amount for movable equipm: \$ 19,291Description: 02 Concentrator, Wheelchairs, Gericharis, Elect. Beds, etc.

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$ _____13. /2002 \$ _____14. /2003 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number Manorcare of Northbrook

#

0042648Report Period Beginning: 06/01/99 Ending: 05/31/00**XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)****A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**1. HAVE YOU TRAINED AIDES
DURING THIS REPORT
PERIOD?☐ YES☒ NOIf "yes", please complete the remainder
of this schedule. If "no", provide an
explanation as to why this training was
not necessary.2. CLASSROOM PORTION:IN-HOUSE PROGRAM ☐IN OTHER FACILITY ☐COMMUNITY COLLEGE ☐

HOURS PER AIDE _____

3. CLINICAL PORTION:IN-HOUSE PROGRAM ☐IN OTHER FACILITY ☐

HOURS PER AIDE _____

B. EXPENSES**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities

\$ **D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

our
ies.

Facility Name & ID Number Manorcare of Northbrook# 0042648

Report Period Beginning:

06/01/99

Ending:

05/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4		5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)	Supplies (Actual or Allocated)		Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)				
			Units of Service	Cost		Units	Cost						
1	Licensed Occupational Therapist	10A	1,873	hrs	\$ 46,828	129	\$ 3,229	\$ 1,301	2,002	\$ 51,358	1		
2	Licensed Speech and Language Development Therapist	10A	602	hrs	15,045	218	5,448	80	820	20,573	2		
3	Licensed Recreational Therapist			hrs							3		
4	Licensed Physical Therapist	10A	4,603	hrs	83,461	129	3,234	2,953	4,732	89,648	4		
5	Physician Care			visits							5		
6	Dental Care			visits							6		
7	Work Related Program			hrs							7		
8	Habilitation			hrs							8		
9	Pharmacy	39		# of prescripts				122,805		122,805	9		
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10		
11	Academic Education			hrs							11		
12	Exceptional Care Program										12		
13	Other (specify): X-Ray & Lab	39					22,452			22,452	13		
14	TOTAL				\$ 145,334	476	\$ 34,363	\$ 127,139	7,554	\$ 306,836	14		

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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Facility Name & ID Number Manorcare of Northbrook

0042648

Report Period Beginning: 06/01/99

Ending:

05/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/00

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 101,175	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (186,986))	748,883		3
4	Supply Inventory (priced at)	13,973		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 864,031	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	2,523		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	24,817		16
17	Accumulated Depreciation (book methods)	(5,003)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP	13,233,884		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 13,256,221	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 14,120,252	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 16,964	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	123,359		30
31	Accrued Taxes Payable (excluding real estate taxes)	(8,149)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	47,196		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	242,247		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 421,617	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 421,617	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 13,698,635	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 14,120,252	\$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (465,117)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (465,117)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	441,114	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 441,114	17
	B. Transfers (Itemize):		
18	Change In Interdivision	13,722,638	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 13,722,638	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 13,698,635	24 *

* This must agree with page 17, line 47.

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STATE OF ILLINOIS

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Facility Name & ID Number Manorcare of Northbrook

0042648

Report Period Beginning: 06/01/99

Ending:

05/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,840,175	1
2	Discounts and Allowances for all Levels	(1,166,455)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,673,720	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	634,290	6
7	Oxygen	(3,758)	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 630,532	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	748	12
13	Barber and Beauty Care	16,317	13
14	Non-Patient Meals	943	14
15	Telephone, Television and Radio	5,951	15
16	Rental of Facility Space		16
17	Sale of Drugs	110,706	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,667	19
20	Radiology and X-Ray	83	20
21	Other Medical Services		21
22	Laundry	10,805	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 150,220	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	11,355	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,355	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,465,827	30

2			
Expenses		Amount	
A. Operating Expenses			
31	General Services	\$ 654,956	31
32	Health Care	1,810,796	32
33	General Administration	1,209,662	33
B. Capital Expense			
34	Ownership	71,551	34
C. Ancillary Expense			
35	Special Cost Centers	277,748	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,024,713	40
41	Income before Income Taxes (line 30 minus line 40)**	441,114	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 441,114	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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